Gray Davis, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
Headquarters Address:
980 9th Street, Suite 500
Sacramento, CA 95814

December 11, 2002

IN REPLY REFER TO
FILE NO.: Alpha
LOG NO.: Alpha

To: All Full Service and Specialized Mental Health Plans and Applicants for Licensure

From: Linda Azzolina, Counsel

Re: AB 1401; COBRA/Cal-COBRA Extension and Individual Conversion Coverage Requirements

In September, Governor Gray Davis signed into law AB 1401 (Thomson), which enhances access to health care coverage in the individual market by expanding Cal-COBRA coverage requirements, revising requirements for individual conversion coverage and creating a guaranteed issue Major Risk Medical Insurance Program ("MRMIP") "graduate" product.

The November 4, 2002 advisory of the Department sent to full service health plans related to MRMIP graduate product offering requirements and the matrix information filing.

This December 11, 2002 advisory provides information regarding Cal-COBRA extension and individual conversion requirements in AB 1401 for full service health plans and specialized health plans that offer group contracts.

Extension of COBRA/Cal-COBRA

For enrollees whose Cal-COBRA coverage begins on or after January 1, 2003, Section 1366.27 as amended applies to full service and specialized health plans. The statute extends Cal-COBRA coverage to 36 months after the date a qualified beneficiary's benefits under a group plan contract would otherwise have terminated by reason of a qualifying event.

For enrollees whose COBRA coverage begins on or after January 1, 2003, Section 1366.29 added to the Health and Safety Code applies to full service plans and those specialized health plans that provide core benefits as defined in Section 1366.21, namely, basic health care services under Section 1345(b) or other hospital, medical or surgical benefits. This includes specialized mental health plans that offer group contracts and excludes specialized dental, vision, chiropractic and acupuncture plans.

Full service plans that contract with specialized mental health, dental, vision, chiropractic and acupuncture plans are required to provide enrollees the full service and specialized benefits under COBRA/Cal-COBRA. In addition, full service plans are required to comply with Section 1366.29 as to both the full service and specialized benefits. Specialized mental health plans that have direct contracts with employer groups are required to comply with Section 1366.29.

Plans must offer enrollees who have exhausted their COBRA continuation coverage the opportunity to continue coverage up to 36 months from the date the continuing coverage began if the enrollee is entitled to less than 36 months under COBRA.

Requirements for Offering Individual Conversion Coverage

Under Section 1373.6, as amended, full service health plan group contracts entered into, amended, or renewed on or after September 1, 2003, that provide individual coverage other than conversion, must offer an individual conversion contract that mirrors one of two plans required to be offered to enrollees in accordance with the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") for federally eligible defined individuals, as referenced in Section 1366.35, at the same rates as required for federally qualified individuals unless the plan is a federally qualified health maintenance organization.

Beginning on September 1, 2003, full service plans that do not provide individual health care service plan contracts must offer an individual conversion contract in accordance with Section 1366.35, which requires plans to mirror the most popular HMO and PPO contracts. Full service plans that offer HMO contracts must offer the most popular health maintenance organization ("HMO") contract. Full service plans that offer preferred provider organization ("PPO") contracts must offer the most popular PPO contract. The most popular HMO and PPO contracts must be identified by the Department, based on the contracts which have the greatest number of enrolled individuals on January 1 of the prior year. Plans subject to this requirement must offer the most popular HMO or PPO contracts with the same cost-sharing terms and premium as for HIPAA contracts under Section 1399.805.

The Department has determined that as of January 1, 2002 the most popular HMO product is a Kaiser HMO plan and the most popular PPO product is a Blue Shield PPO plan. A detailed benefits matrix, including pricing information, based upon these two products will be sent to plans next week. This information should be used by plans that do not provide individual health care service plan contracts to revise their individual conversion contracts.

Amendment Filings

By **December 31, 2002**, if a plan determines that it is not required to comply with any or all of the COBRA/Cal-COBRA and/or individual conversion requirements, it is required to file an amendment as indicated below that sets forth the basis for its determination of inapplicability.

By December 31, 2002, all full service and all specialized plans should (i) file an amendment to their Evidences of Coverage and/or Evidences of Coverage/Disclosure Forms that includes a representation that it will comply with Sections 1366.27 and 1366.29 as added to or amended as of January 1, 2003, relating to COBRA/Cal-COBRA, whether or not it has provided notice of such revisions by mail or other notice to enrollees by January 1, 2003, and (ii) file by **January 31, 2003,** an amendment with redlined changes to the above referenced documents that includes revisions to its description of COBRA/Cal-COBRA coverage to inform enrollees of the extension of coverage. Following the Department's approval, plans should include notice of such changes in its next mailing to enrollees which may include but not be limited to the notice of election of continuation coverage, a newsletter, amendment to Evidence of Coverage or other endorsement.

By January 31, 2003, all full service plans are required to complete and file two comparative benefit matrices based on templates provided by the Department under Section 1363.06 set forth in AB 1401. One matrix relates to the MRMIB guaranteed product and the other relates to the individual conversion/HIPAA product. See the section on comparative benefit matrices below for further details.

By April 1, 2003, in order for the Department to ensure compliance with the revisions to Section 1373.6, all full service plans should file an amendment that includes the following information:

(a) Each plan that offers individual plan contracts, other than conversion contracts should file:

    (i) a representation that it will offer one of the two plans that it is required to offer to federally eligible defined individuals in accordance with HIPAA under Section 1366.35,

    (ii) a representation that the plan contract to be offered is on a form that has been previously filed and approved by the Department including the date of filing and approval by the Department, and

    (iii) if the form of contract has not been filed and approved by the Department, file the contract for the Department's review under Exhibit Q.

(b) Each plan that does not offer coverage under individual plan contracts should file:

    (i) a form of HMO health benefit plan contract and individual conversion benefit matrix. A copy of the template for the matrix is attached. Please see below for

additional information.

(ii) the premium and cost-sharing terms, and

(iii) Exhibit Q, the individual contract or Exhibits Q and T or U, as applicable for plans that use a combined subscriber contract and Evidence of Coverage or Evidence of Coverage/Disclosure Form.

Additional Information Relating to the Comparative Benefit Matrices

Included with this advisory is the blank template of comparative benefit matrix for the individual conversion/HIPAA product.

Plans that currently offer individual benefit contracts should complete the matrix and submit it to the Department by January 31, 2003. Plans that currently do not offer individual health contracts should complete the matrix based on the information to be provided by the Department detailing benefits and premium information for the most popular HMO and PPO plan contracts.

Once the comparative benefit matrices are completed and filed with the Department, the Department along with the Department of Insurance will make the completed templates available to the public on their internet websites so that enrollees may easily compare benefit packages.

All amendment filings should clearly state in the cover letters that they relate to AB 1401. For filings due on January 31, 2003, plans should prepare two separate amendment filings, one that includes the comparative benefit matrices and one that includes revisions to subscriber documents relating to COBRA/Cal-COBRA.

If you have any questions regarding this advisory please contact me at (213) 576-7600.